STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004765	A. BUILDING: _____ B. WING _____	06/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUTNAM COUNTY HOSPITAL	1542 S BLOOMINGTON ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a State hospital complaint. Complaint Number: IN00125784 Substantiated: No deficiencies related to the allegations are cited. Date: June 17, 2013 Facility: 004765 Surveyor: Billie Jo Fritch RN, MBA, MSN Public Health Nurse Surveyor Putnam County Hospital is in compliance with 410 IAC 15-1.5-5, Medical staff, Hospital Licensure Rules. QA: claughlin 07/25/13	S 000		